FEB 18 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1250 210

Registration District No. 399 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
General Hospital #2 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1-4-41 to 1-9-41 (Specify whether
In this community 22 years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL") 0

(d) Street No. 2442 Michigan
(If rural, give location) 0

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John Turner

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex Male

5. Color or race Negro

6. (a) Single, widowed, married, / divorced Married

6. (b) Name of husband or wife Retter Turner

6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased 7 (Month) 11 (Day) 1880 (Year)

8. AGE: Years 60 Months 5 Days 29 If less than one day hr. min.

9. Birthplace Bonner Springs (City, town, or county) / Kansas (State or foreign country)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant's own signature Record Clerk
(b) Address Gen. Hosp. #2

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-14-41 (Month) (Day) (Year)
(c) Place: burial or cremation Highland

18. (a) Signature of funeral director Adkins Bros.
(b) Address 2000 E. 12 K. C. Mo.

19. (a) Jan 14 1941 (Date received local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 9
year 41 hour 5 minute 5 A. M.

21. I hereby certify that I attended the deceased from 1-4- 1941 to 1-9- 1941;
that I last saw h 1m alive on 1-9- 1941;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic Pneumonia /	
Due to: Hypertensive Heart Disease.	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations:
Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature G. A. Stevens (M. D. or other)
Address Gen. Hosp. #2 Date signed 1-14-41

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

I X10811

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Edward Evans

Licensed Embalmer No. 3836

P. O. Address 1619 E. 15th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
-2-21-40
I X22659

DEPARTMENT OF COMMERCE
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STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. Primary Registration District No. Registrar's No. 210

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County Jackson

(b) City or town K. C.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME John Turner

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race B

6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive years

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day: hr. min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 1/14/41 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. 9 day 1941
year hour minute M.

21. I hereby certify that I attended the deceased from , 19, to , 19;
that I last saw h alive on , 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia
Duration
Due to Bronchial
Due to Hypertensive heart disease.
Other conditions (Include pregnancy within 3 months of death) 90 L1

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-1250